Care Net Nigeria

Health Insurance Affairs

Volume 2, Issue 4

April 2010

ISSN 2006 - 7658

INSIDE THIS ISSUE:

Your Feedback	2
Nigeria Develops an Investment Plan: 2010 to 2015	3
Succession Crises at the National Health Insurance Scheme	3
A Fresh Look at "Market-Based Solutions"	4
Editorial - A message from America	4

For Enquiries Contact:

CARE - NET LTD

Plot 16 Ibaa Street

TMC Estate, Abuloma

Port Harcourt 500001

Rivers State, Nigeria

Tel: +234 - 84 - 770232

E-mail: info@carenet.info

Website: www.carenet.info

President Obama's Health Care Reforms: What lessons for SSA?

Health care is a universal need, and as President Obama signed a new healthcare bill into law that will expand coverage to millions of Americans who otherwise have been left without cover - many observers have noted that this event will have a ripple effect all over the whole world. This is especially so in Sub-Saharan Africa (SSA) where over half of the population do not have access to modern health care services.

Apart from putting 'health' at the centre of the political agenda, there is now a clear demonstration that health care is too serious a business to be left to politicians and professionals. Indeed, as many of the countries in SSA profess to be adopting liberal democracy in one form or the other, there is now a huge opportunity for citizens and civil society to galvanize around health as a major issue that enables whole countries to make progress towards achieving set human development targets.

"I'm not the first president to take up this cause, but I'm determined to be the last"

But rather than attempting to be doing so much with little impact, the events in USA point to one critical area, and that is, finding mechanisms for providing financial risk protection for the entire population. And as the World Health Organization has repeatedly argued, the means of achieving universal coverage is irrelevant so long as people are protected from financial risk of ill health.

As the lack of money to pay for health care continues to be a significant constraint for people to have access to a comprehensive package of essential health care services - the time to act is now. This requires political will as well as the courage to stand firm and carry through the much needed reforms ◊◊◊

...and in Rivers State, Nigeria - a missed opportunity

What would have been a model social health insurance programme in Nigeria and indeed the rest of Africa was bungled - partly due to poor advice from political cronies and Governor Ameachi's lack of courage to undertake the needed reforms.

After a lengthy structured planning process, starting with a 'Health Summit' followed by a 'Conference on Health Insurance' and the development of a State Health Policy approved by the Executive Council (Exco)- an Executive Memo for the establishment of a Rivers State Health Insurance Programme was sent to the Exco by the Commissioner of Health - Dr Sampson Parker. Prior to that a study tour of existing approaches to health financing in the country was undertaken by a technical committee, with a view to determining what would be most suitable for Rivers State.

...Continued on page 3

Poor advice and lack of courage prevented him from acting wisely

Your Feedback...

Community Based-Health Insurance: Are We Taking On Board Lessons Learnt?

Thanks for the publication - *Health Insurance Affairs*, January 2010. It was an interesting reading.
The push for Community -Based Health Insurance in Nigeria is scratching the surface and cannot address the fundamental issue of providing health to those that need it at the grass roots. First, the delivery system is weak, the group targeted will always require a subsidy because of their disease burden vis-à-vis their socio-economic status, which cannot be sustained indefinitely.
I have been of the opinion that health care delivery in a society like ours, Nigeria is a social responsibility of the government, although it cannot do it alone. There has to be a social security system to cater for the vulnerable through a contributory system as obtained in UK or Canada especially here where the large majority of the population is in the informal sector. We do not seem to be taking on board the lessons learnt in SSA.

Dr Dan Iya
Jos, Nigeria

Thank you for this article, but universal health insurance is a level of coverage that could be attained through either of the two approaches. We cannot be talking of "Social Health Insurance" when the mass of our population are in the informal sector or are rural dwellers. Social health insurance and community health insurance are financing approaches involving beneficiaries as key contributors to the funding as against relying on only government funding. Both can be complementary as you work towards universal health care coverage. The problem of the article is that it fails to highlight the differentiating factors of the two (i.e. "Social and Community").
Unless we understand the operational mode of each of these approaches (Social Health Insurance or Community Health Insurance) one may then be analysing their merits and demerits. There is no need for such analysis at all.
I shall do an article on this and forward same to you shortly. Please I encourage that we push this for public debate so that in the end, more people could have a clearer picture of health insurance. Please keep-up your publication on health issues. God bless you.

Paul Akeni
Abuja, Nigeria

A Uniform Accreditation System

I just read the January 2010 edition of the newsletter.
In particular I find the report on a unified accreditation system interesting.
One of the mandates of the Medical and Dental Council of Nigeria (MDCN) is to regulate medical practice in Nigeria.
Does this regulation include accreditation, licensing and registration of practice and premises? If it does, then
the role of universal accreditation (of government and private premises) should be passed on to the MDCN.

This brings me to the issue of the role of the MDCN in Nigeria and in particular in the NHIS. Don't you think that the body should have become almost autonomous and self-funding by now rather than waiting for government subventions? It was shameful that the doctors who headed that body in the recent past only fought to retain their offices rather than try to make the body relevant to the scheme of health service provision in the country.
If this role would also be left solely to the MDCN then the members of the Council should not just be doctors and dentists only as it presently is. The presence of lay citizens on the board would be necessary for transparency and accountability.

Who regulates HMOs? NHIS?

Dr Tolulope Ayangbayi

Lagos, Nigeria

Editor's Comments:

With respect to your last question - who regulates HMOs? NHIS? - this has been recognised as a fundamental flaw in the design and operation of the scheme. As you would have noticed, the current NHIS is both an organisation and the institutional framework of health insurance in the country. In this instance, it is both an operator (as it receives and disburses funds) and a pseudo regulator (as it registers HMOs and accredits Providers). In several communications - Health Insurance Affairs has maintained that the NHIS should undergo fundamental reformation.

We have suggested that the National Health Insurance Scheme (NHIS) should be repositioned as a System (rather than as an institution) consisting of a Regulator, Health Insurance Funds, Programmes, and Operators. By creatively working within the existing legal framework, the regulatory functions should be delinked from that of funding and provision. In accordance with section 7 of the current NHIS Law (Decree 35 of 1999) the Council should begin to assume the regulatory role expected of an omnibus regulator, which may later transform to a National Health Insurance Commission (NHIC). All current programmes should be merged into a Programmes Department and begin to function as a National Health Insurance Fund (NHIF) coordinating the mobilisation and management of Social Health Insurance contributions from the public sector including those covering the vulnerable groups such as the MDGs Fund for pregnant women and children under the age of five years. The establishment of Private Health Insurance Funds (PHIFs) including Micro Health Insurance Funds (MHIFs) should be actively encouraged, to develop and manage Private Health Insurance Plans targeted at the private sector including the informal sector. The Council should also ensure that there is a clear split between Insurers (Purchasers) and Providers. It should work with the Medical and Dental Council of Nigeria (MDCN) and the 36 States and the Federal Capital Territory (FCT) to ensure that an effective Provider accreditation system that guarantees optimal standard of care for beneficiaries is put in place.

Great Job!

The newsletter is informative and enlightening. It addresses issues on and surrounding the critical business of healthcare. And it delivers this in-your-face and thought-provokingly, never failing to express the urgency of the desperate existing state of affairs of the healthcare industry in SSA.

Dr Chris Igharo
Abuja, Nigeria

Nigeria Develops an Investment Plan: 2010 to 2015

The Federal Ministry of Health in Nigeria has successfully steered the development of a strategic health development plan for the country, for the period 2010 to 2015. This plan, which was prepared through a collaborative and participatory process involving all the States, the private sector, civil society and development partners, provides an overarching reference for investment in the health sector and mutual accountability based on a results framework linked to the health-related Millennium Development Goals (MDGs).

Apart from a harmonized National Strategic Health Development Plan (NSHDP), each of the 36 States and the Federal Capital Territory (FCT), Abuja - have their respective plans that also serve the same purpose at the sub-national level.

While this appears to be a significant achievement in terms of new ways of working in a complex federal country such as Nigeria, there are concerns on the implementation of these plans. The biggest challenge is with the States - with considerable autonomy, they are very protective of their independence in decision making. This could be further compounded if the Federal Ministry of Health and its Agencies continue to retain control of the flow of funds from the national budget, rather than serve as conduits for disbursement of health care resources to the frontline.

Although there are attempts to get the 'purse holders' at the State level, that is, the State Governors to signed on to these strategic plans, there is strong indication that it may continue to be business as usual. State Governors are still attracted to large, visible, and capital intensive projects that can give them 'political mileage'. At the present moment, after salaries are paid, practically nothing is left for running the health services in the States, in terms of a recurrent budget.

Nevertheless, the NSHDP and its State counterparts provide a useful platform for rational management of public expenditure in the health sector that can assist the country in making accelerated progress towards the health-related MDGs.

> But States are still attracted to large, visible, and capital intensive projects….and practically nothing is left as recurrent budget.

==

Succession Crises at the National Health Insurance Scheme

Following a new term-limit policy of the Federal Government of Nigeria in respect of civil servants at the level of Directors, the Executive Secretary of the NHIS, Dr Dogo Mohammed, was asked to leave.

He contested the action of government, arguing that in his case he had not spent 8 years at this position. But government insisted he had been on an equivalent position prior to his appointment at the NHIS. Moreover, he was also accused of not resigning from his previous appointment after his position as Executive Secretary was confirmed. Not satisfied, Dr Dogo took the government to court .

In the interim a mini drama ensued, whereby he was temporally reinstated and then sacked again, but refused to leave office. At the time of going to press we were informed that although he no longer comes to work, no one has been appointed to take his place.

Poor leadership of the NHIS has been one of the binding constraints preventing rapid expansion of the programme. The absence of a figure head makes the situation even worse. Management of the NHIS is quite pathetic, more so, the Council over the years, has failed to step up to the challenge of providing effective policy direction to achieve results.

As in many things in Nigeria, unless the regulatory environment is streamlined as in the case of telecommunications, meaningful progress cannot be achieved. Secondly, as a private sector driven industry, there will be reduced business confidence as the Federal Government fails to give appropriate stewardship. Similarly, States have been vindicated from refusing to be 'rolled into' a federal programme, given the level of managerial incompetence that has been noted in its implementation.

Nonetheless, many observers agree that despite its failings, a national health insurance programme of this nature that could provide a non-discriminatory, broad-based health care opportunity for all Nigerians should not be abandoned. And that government's role in the scheme of things should be limited to regulation and no more ◊◊◊

==

Missed opportunity in Rivers State, Nigeria

...continued from page 1

With Exco approval a design team crafted a Programme Memorandum and a Draft Bill that was fine-tuned by the Ministry of Justice, ready to be sent to the House of Assembly.

It was at this point that all the preceding plans were set aside in the name of embarking on a so called 'Free Medical Service' in place of the proposed 'social protection scheme.' The original programme, which aimed to achieve 'universal coverage within the shortest possible time - was based on the principles of social solidarity but with shared responsibility. Apart from making counterpart contribution for its employees, government will fully pay the premium of vulnerable groups such as children under 5 years, the elderly above 60 years and others, as well as providing generous premium subsidy for rural dwellers and those in the informal sector.

Other than pandering to populist views, like in many things that happen in Nigeria - vested interests and a tendency to maintain the status quo, which has prevented the country from moving forward could be said to be at work. Otherwise, how can one explain that a government, which is planning to undertake free medical services (that is unsustainable) has since increased user charges in its health centres and hospitals - further creating financial difficulties for ordinary people. If what has just happened in America should cause the Government of Rivers State to re-think - that would be great ◊◊◊

Health Insurance Affairs is a quarterly Newsletter, linking Health Systems and Healthcare Providers in Nigeria.

CARE-NET, publishers of *Health Insurance Affairs*, hope that it will provide information, education and guidance to all stakeholders – government regulators, doctors, nurses, pharmacists and professions allied to medicine, employers, labour unions and patients about their responsibilities and rights in an insurance based health care system.

Readers are invited to contribute views, articles, and letters. Opinions and views expressed in letters and articles do not necessarily reflect the views of CARE-NET. Information supplied in *Health Insurance Affairs* is checked as thoroughly as possible, but cannot accept responsibility should any problem arise.

CARE-NET is an integrated Healthcare Consulting and Management firm. It is a Limited Liability Company registered in Nigeria. RC 370401.

A Message from America

Although having more money for doing more with technology than any other developed country, the health care system in the USA was seen to be grossly inequitable - where over 40 million (30%) of its citizens do not have any form of health insurance cover. Despite strong political opposition from the Republican party that lost the last presidential election, and aggressive resistance from citizen groups opposed to what they see as a creeping socialist agenda, President Obama went ahead with his plans of getting everyone in the USA to have health insurance cover - universal coverage.

With the signing of the bill that will substantially expand coverage to several millions of Americans, obliging everyone to take up health insurance (while providing tapering subsidy for poor families to help them afford it), President Obama has sent a strong message to the world that no one should be left without a means to paying for health care.

For Nigeria and the rest of Sub-Saharan Africa especially, this message should be interpreted to mean that *no amount of development assistance will do*, unless you find a way that enables people have access to vital health care without the financial burden that go with it.

Dr Tarry Asoka
Editor
tarry@carenet.info

This issue of the Health Insurance Affairs is supported by a kind donation from TOTAL HEALTH TRUST LTD - a foremost Health Maintenance Organization (HMO) based in Lagos, Nigeria.

A Fresh Look at "Market-Based Solutions"

In the face of bureaucratic incompetence and corruption, there is renewed call for the adoption of 'market-based solutions' as a means of helping those living at the bottom of the global income pyramid. Apart from being an alternative that give low-income people better access to socially beneficial products and services, which genuinely and directly improve their lives and livelihood; market-based solutions are seen to also complement traditional government expenditures, international Aid and philanthropy.

The current interest in market-based solutions derive not only from the success of microfinance but also as a powerful model in the fight against poverty. Against this backdrop, the Monitor Group in its report *Emerging Markets, Emerging Models: Market-Based Solutions to the Challenge of Global Poverty*, has identified several examples in India. These include: clean drinking water at a quarter of the cost of the least expensive alternative; private education in urban slums that significantly outperforms government schools for about $3 a month; Doctor-attended safe birth for less than a forth of the cost in traditional private hospitals; and as much as 125% increase in incomes for small farmers.

While the report notes that there is much yet to learn about what causes market-based solutions to succeed or fail, the most successful ones have been seen to have passed two tests. They have been observed to be self-funding, as well as operating at sufficient scale to make a difference to the masses of poor people. In addition, they exhibit one salient feature common to all, which is, the adoption of a business model tailored to the special circumstances of markets at the base of the income pyramid.

This presents a very attractive proposition and challenge for organizations and individuals who are concerned with increasing health insurance coverage for low-income persons. It is also hoped that governments and Aid Agencies will recognized the promise of market-based solutions in this instance, and act to encourage them ◊◊◊